SUPERVISOR'S CHECKLIST

Injury Reported – MUST SUBMIT CA-1 OR CA-2 TO RECEIVE OWCP CLAIM NUMBER

- Submit Electronically using EDI – This cannot be assigned to another individual to complete, due to Privacy Act Laws
- Submit CA-1 Traumatic Injury or CA-2 Occupational Disease
- Website: www.cpms.osd.mil/ICUC/ICUC_index.aspx
- Select the link to the left titled: "Filing Claims Electronically"
- For Recurrence Claims – File the CA-2a Manually to ICPA

Notify Safety

- Submit local Safety Forms to your Safety Officer
- DO NOT PROVIDE SAFETY WITH CLAIM FORMS (CA-1/2)OR MEDICAL DOCUMENTATION
- If Safety Office asks for copies of claim forms – notify ICPA

Medical Documentation – MUST BE SIGNED BY A PHYSICIAN (Medical Doctor)

- CA-16, Employee must be returned to the ICPA within 10 calendar days.
- CA-20, Attending Physician's report (completed each time medical treatment is received and/or office visit)
- CA-17, Duty Status Report (completed after each change in treatment/work status change, i.e. work restrictions)
- INJURED EMPLOYEE MUST NOTIFY PHYSICIAN THAT AGENCY OFFERS LIGHT DUTY

Continuation of Pay (COP) – Must be supported by Medical Documentation

- 45 Calendar days entitlement following date of traumatic injury
- Time Card Code for COP: "LU" for date of injury; "LT" for lost time after injury (maximum of 45 days)
- Four digit code for time card is month and day of injury
- If claim is denied, change COP to Sick Leave (LS), Annual Leave (LA) or LWOP (employee will make the decision on which they would like to use)

Medical Authorization – Must be supported by medical justification

- Physician requests authorization : Phone (850-558-1818) or fax (800-215-4901) or Wesite: http://owcp.dol.asc-inc.com
- Medical Provider much has ACS Provider Number to receive authorization

- Physician must state IDC-9 Code (diagnosis code), CPT (Procedure code), and OWCP Claim Number. Requested treatment/procedure must match accepted condition.

Compensation after 45 days of COP – Must be supported by Medical Documentation

- Must be in a LWOP (Leave without Pay) Status
- Complete CA-7, Claim for Compensation, every two weeks until notified by OWCP or ICPA no longer necessary
- Submit SF-1199A, Direct Deposit along with first CA-7 submitted
- After 80 hours of LWOP, submit SF-52 to HRO requesting LWOP status
- Pay Rate is three-fourths of salary for with dependents and two-thirds without dependents.

Medical Bills

- Website: http://owcp.dol.acs-inc.com
- Medical Provider must have an ACS Provider Number to receive payment
- Bills submitted manually must be submitted on HCFA-1500 or US-92
- Mailing address: Department of Labor, P.O. Box 8300, London, KY 40742-8300
- ACS Customer Service: 850-558-1818

Reimbursement

- OWCP-915, Medical expense reimbursement, submit with required documentation
- OWCP-957, Travel Reimbursement, submit with medical documentation
- Send completed forms, along with medical documentation to Department of Labor, P.O. Box 8300, London, KY 40742-8300

Agency Point of Contact

- Injury Compensation Program Administrator (ICPA) in your Human Resources Office is Georjeana Halstead, 757-878-1146, georjeana.halstead@us.army.mil

What A Federal Employee Should Do When Injured At Work

Report to Supervisor

Every job-related injury should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices.

Obtain Medical Care

Before you obtain medical treatment, ask your supervisor to authorize medical treatment by use of form CA-16. You may initially select the physician to provide necessary treatment. This may be a private physician or, if available, a local Federal medical officer/hospital. Emergency medical treatment may be obtained without prior authorization. Take the form CA-16 and form OWCP-1500/HCFA-1500 to the provider you select. The form OWCP-1500/HCFA 1500 is the billing form physicians must use to submit bills to OWCP. Hospitals and pharmacies may use their own billing forms. On occupational disease claims form CA-16 may not be issued without prior approval from OWCP.

File Written Notice

In traumatic injuries, complete the employee's portion of Form CA-1. Obtain the form from your employing agency, complete and turn it in to your supervisor as soon as possible, but not later than 30 days following the injury. For occupational disease, use form CA-2 instead of form CA-1. For more detailed information carefully read the "Benefits ..." and "Instructions ..." sheets which are attached to the Forms CA-1 and CA-2.

Obtain Receipt of Notice

A "Receipt" of Notice of Injury is attached to each Form CA-1 and Form CA-2. Your supervisor should complete the receipt and return it to you for your personal records. If it is not returned to you, ask your supervisor for it.

Submit Claim For COP/Leave and/or Compensation For Wage Loss

If disabled due to traumatic injury, you may claim continuation of pay (COP) not to exceed 45 calendar days or use leave. A claim for COP must be submitted no later than 30 days following the injury (the form CA-1 is designed to serve as a claim for continuation of pay). If disabled and claiming COP, submit to your employing agency within 10 work days medical evidence that you sustained a disabling traumatic injury. If disabled beyond the COP period, or if you are not entitled to COP, you may claim compensation on form CA-7 or use leave. If disabled due to occupational disease, you may claim compensation on form CA-7 or use leave. A claim for compensation for disability should be submitted as soon as possible after it is apparent that you are disabled and will enter a leave-without-pay status.

The Federal Employees' Compensation Act (FECA) is administered by the U.S. Department of Labor, Employment Standards Administration, Office of Workers' Compensation Programs (OWCP). Benefits include continuation of pay for traumatic injuries, compensation for wage loss, medical care and other assistance for job-related injury or death. For additional information about the FECA, read pamphlet CA-11, "When Injured at Work" or Federal Personnel Manual, Chapter 810, Injury Compensation, available from your employing agency. The agency will also give you the address of the OWCP Office which services your area.

Post on Employees' Bulletin Board

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

U.S. GOVERNMENT PRINTING OFFICE: 1991 0-866-435

Form CA-10
Rev. Aug. 1987

EMPLOYEE RIGHTS AND RESPONSIBILITIES WHEN INJURED AT WORK

It has come to our attention that you have been involved in a work-related accident. We would like to take this opportunity to advise you of some of the benefits and responsibilities that are accorded by the Federal Employees' Compensation Act (FECA) should you file a workers' compensation claim.

The Office of Workers' Compensation Programs (OWCP) administers the FECA and has sole adjudication authority for federal workers' compensation claims. The ICPA office, in conjunction with the Civilian Personnel Management Service, Injury & Unemployment Compensation Division, is responsible for monitoring your entitlement to the benefits outlined within the FECA and administered by the OWCP.

FILING A WORKERS' COMPENSATION CLAIM

If you voluntarily elect to file a workers' compensation claim in relation to the reported accident, please complete the on-line OWCP Form CA-1 or CA-2 with your supervisor.

Form CA-1, Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation may be completed to report a traumatic injury, which is an injury that has occurred within one tour of your regular duty. Form CA-1 should be filed within 30 days of the injury.

Form CA-2, Notice of Occupational Disease and Claim for Compensation, may be completed to report an occupational disease, which is an injury or illness that has developed over a period greater than one tour of official duty. Form CA-2 should be filed within 30 days of the date you realized the disease or illness was caused or aggravated by the employment.

When filing a claim for Occupational Disease or Illness, you must submit the specific detailed information described on Form CA-2 and on any checklist (Form CA-35, A-H) provided by your supervisor or the human resources office. OWCP has developed these checklists to address particular occupational diseases. Medical reports must also include the information specified on the checklist for the particular disease claimed.

Once a claim has been filed with the OWCP, you have the right to withdraw your workers' compensation claim, (but not the notice of injury) by so requesting in writing to OWCP through your responsible ICPA office at any time before OWCP determines eligibility for benefits.

OBTAINING MEDICAL TREATMENT

You have a right to choose your treating physician. You must notify your supervisor of your preferred choice prior to scheduling an appointment. Any request by your supervisor or the occupational health clinic to be evaluated by medical clinic or contract physician must not interfere with your preferred physician appointment.

When an appointment with your preferred physician is requested for a traumatic injury, your supervisor may complete the front of Form CA-16, "Authorization for Examination and/or Treatment". In an emergency, where there is no time to complete the form, the ICPA office may authorize medical treatment by telephone and then forward Form CA-16 to the medical facility within 48 hours. Retroactive issuance of Form CA-16 is not allowed under any other circumstance. Your supervisor, or the ICPA office may refuse to issue a CA-16 if more than 48 hours has elapsed since the injury occurred, or the treatment is based on an Occupational Disease or Illness.

If you require medical treatment because of a work-related occupational illness, it is recommended that you obtain care directly from a physician, preferably from a specialist in the indicated field. If OWCP accepts the claim, medical treatment required by the condition(s) accepted, including treatment received before acceptance may be reimbursed to you or your health insurance carrier by the OWCP after adjudication. Form CA-16 may not be used to authorize treatment for occupational disease or illness except in very unusual situations.

For each type of claim, you are responsible for submitting, or arranging for submittal of a medical report from the treating physician for every medical service provided to you resulting from the job-related injury. You must also submit medical evidence showing that the condition claimed is disabling when applying for wage loss benefits.

Medical reports from service providers must include the following:

- Dates of examination and treatment
- History given by you
- Physical findings
- Results of diagnostic tests
- Diagnosis
- A description of any other conditions found but not due to the claimed injury;
- Treatment provided or recommended for the claimed injury
- Physician's opinion, with medical reasons, as to causal relationship between the diagnosed condition(s) and the factors or conditions of the employment;
- Extent of disability affecting your ability to work due to the injury;
- Prognosis for recovery; and
- Work limitations

MEDICAL BILL PAYMENTS

Your provider has the option of sending bills for injury-related treatment or services electronically, or in paper form. Providers that elect to submit bills electronically must enroll as a DOL provider by completing the Provider Enrollment Form at the following web address:

https://owcp.dol.acs-inc.com/portal/pdf/Provider_Enrollment_Form_Final.pdf

OWCP will pay appropriate charges for medical treatment if your case is approved and the treatment was necessary for the job-related injury. OWCP applies a schedule of maximum allowable medical charges to pay work-related bills submitted by a provider of service. OWCP will only authorize payment of treatment or services that are related to an accepted work-related condition.

You are not responsible for paying the difference between the maximum charge set by the schedule for a particular treatment and the charge made by the provider for bills submitted on an OWCP accepted claim. You are, however, responsible for payment of medical bills resulting from an occupational disease or illness until a claim is accepted by the OWCP.

You may be reimbursed for employee-paid medical, surgical, and dental services using Form **HCFA-1500, American Medical Association Standard Health Insurance Claim Form**, or **OWCP-1500**, the version of the form, which includes instructions for submitting bills to OWCP. The provider must sign the form. For pharmacy expenses, you should use the Universal Claim Form, to include the name of the drug; name of prescribing physician and the date the prescription was filled.

Additionally, you must also complete Form CA-915, Claimant Medical Reimbursement Form, and submit a copy with each Form HCFA-1500, OWCP-1500, or Universal Claim Form. Claims for hospital charges must be submitted on Form UB-92. All forms are available through the ICPA office, or at:

For payment reimbursement, it is recommended that you submit proof of payment, along with the proper forms. OWCP will accept signed statements by providers, a mechanical stamp showing receipt of payment, photocopies of canceled checks (both front and back), or a copy of a credit card receipt.

Both provider bills, and employee reimbursements must be submitted to OWCP within one year after the end of the calendar year in which the expense was incurred, the service was provided, or within a year after the end of the calendar year in which the treated condition was first accepted as compensable by OWCP.

You may review the status of bill submissions for your injury claim by entering the ACS website, and following instructions provided by that website.

ENTITLEMENT TO COP

https://owcp.dol.acs-inc.com/portal/selectUserType.do?program-code=1&user-type=C

Continuation of Pay (COP) is an extension of your regular pay for up to 45 calendar days of wage loss due to disability and/or medical treatment. Your employer pays COP only for claims filed for traumatic injuries. When you request COP, your employer must continue your pay unless it controverts COP for one of the following reasons:

- the disability is due to an occupational disease or illness
- you serve without pay or nominal pay, or are appointed to the staff of a former President, or are selected pursuant to Chapter 121 of Title 28 and serve as a petit or grand juror, and are not otherwise an employee of the United States
- you are neither a citizen nor a resident of the United States or Canada (i.e., a foreign national employed outside the United States or Canada
- the injury occurred off the Agency premises and you were not engaged in authorized "off premises duties";

- the injury was caused by your willful misconduct; or by your intent to bring about injury or death of yourself or another person; or by your intoxication from alcohol or illegal drugs;
- the injury was not reported on a form approved by OWCP (usually Form CA-1) within 30 days after the injury
- you first stopped work more than 45 days after the injury
- you first reported the injury after employment ended
- You are enrolled in the Civil Air Patrol, Peace Corps, Job Corps, Youth Conservation Corps, work-study program, or other group covered by special legislation

Your employer may stop COP if

- you do not provide appropriate medical evidence of a disabling traumatic injury within 10 calendar days of claiming COP. COP is reinstated where evidence received at a later date supports disability.
- your physician has found you to be partially disabled and you refuse suitable work, or fail to respond to the job offer.
- Your scheduled period of employment ends, or employment otherwise ends, provided the period of employment or date of termination is set before the injury occurs

COP can be stopped if employment ends due to disciplinary action in situations where preliminary written notice of termination or other action was issued before the injury occurred and the termination or other action became final during the COP period.

Also any continuation of pay (COP) granted to you after a claim is withdrawn must be charged to sick or annual leave, or considered an overpayment of pay consistent with 5 U.S.C. 5584, at your option.

LIGHT DUTY AVAILABILITY

Employees who are disabled from their regular jobs are expected to return to suitable light duty identified by the supervisor, or the ICPA office. If light duty work is available and offered, you must notify your attending physician and request him/her to specify the limitations and restrictions that apply. Thereafter, immediately advise your supervisor or the ICPA office of the limitations and restrictions imposed by your physician.

If offered light duty work within the limitations and restrictions imposed by your attending physician, you are obligated to return to duty unless you are entitled to, and request leave under FMLA. If you choose not to accept the light duty job offer, you may not be entitled to COP, or wage loss compensation from the OWCP.

CLAIMS FOR COMPENSATION

Compensation payments may be made after wage loss begins and the medical evidence shows that you cannot perform the duties of your regular job. For a traumatic injury, compensation is payable after the 45 days of COP have ended and three waiting days have elapsed. For traumatic injuries where there is no entitlement to COP, and for non-traumatic injuries, compensation is payable after three waiting days have elapsed. In either instance, no waiting period is required when permanent disability exists, or when the disability causing wage loss exceeds 14 days.

Compensation is paid at two-thirds of your pay rate if you have no dependents, or three-fourths of the pay rate if you are married or have one or more dependents. The pay rate is based on your pay on the date of injury, the date disability began, or the date of recurrence. The only regular deductions from compensation are for your share of health benefit premiums, optional life insurance, and post-retirement basic life withholdings if you are enrolled in these plans.

In order for you to claim compensation, you must be in a Leave-Without-Pay-Injury-On-Duty (LWOP-IOD) status with your employer.

Form CA-7, Claim for Compensation, is used to claim compensation for loss of pay. Each payment of compensation must be supported by a medical report from a physician that shows you are disabled for work during the period for which compensation is claimed. It is your responsibility to arrange for submittal of such medical reports.

LEAVE BUY-BACK

Instead of LWOP ("KD" hours type code), you may use sick or annual leave to cover disability periods, however, this is not required, or advised. Doing so can cost you a significant amount of money and delay to repurchase the leave used. It is often preferable to use LWOP (KD) and claim compensation instead.

The leave buy-back process allows you to repurchase annual and sick leave subject to your employer's guidelines. OWCP does not require that your employer grant your leave buy-back request. This is solely

the decision of each individual agency. When your claim is approved and medical evidence shows that you were unable to work because of the injury during the period claimed; you may request a "leave buy-back." You must submit Forms CA-7, CA-7a and CA-7b to OWCP through the ICPA office.

You will owe your employer the difference between the amount paid for leave, which is 100 percent of your usual wage rate, and the amount paid for compensation, which is two-thirds or three-fourths of the wage rate. When this difference is paid, your employer's payroll office will then restore the annual and sick leave to your account and replace them with LWOP (KD) hours. For each 80-hour increment of restored annual and sick leave that is converted to LWOP (KD), your leave account may be reduced by 4 hours of sick leave and either 4, 6 or 8 hours of annual leave dependent upon your leave accrual rate. The repurchase of leave can also affect your income taxes.

PERMANENT IMPAIRMENT

The FECA provides compensation for the permanent loss or loss of use of specified members, functions, and organs of the body. Payment is made for a specified number of days or weeks according to the severity of the impairment. This kind of payment is called a schedule award.

PENALTY FOR FALSE CLAIMS

Whoever knowingly and willfully falsifies, conceals, or covers up a material fact, or makes a false, fictitious, or fraudulent statement or representation, or makes or uses a false statement or report knowing the same to contain any false, fictitious, or fraudulent statement or entry in connection with the application for or receipt of compensation or other benefit or payment under subchapter I or III of chapter 81 of title 5, shall be guilty of perjury, and on conviction thereof shall be punished by a fine under this title, or by imprisonment for not more than 5 years, or both; but if the amount of the benefits falsely obtained does not exceed $1,000, such person shall be punished by a fine under this title, or by imprisonment for not more than 1 year, or both. ~Federal law (18 U.S.C. 1920)

PRIVACY ACT INFORMATION

While workers' compensation records are protected from release under the Privacy Act, your employer is considered a party to the claim. The ICPA office may receive information in your file under the "routine use" provision of the regulations under which the Privacy Act is administered. Such information may include medical reports. The ICPA office is expected, however, to handle this information with care and to restrict access to those with a specific need to have it.

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

Reset | Print

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
[redacted]ying Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

[redacted]oyee Data

1. Name of employee (Last, First, Middle)
2. Social Security Number
3. Date of birth Mo. Day Yr.
4. Sex ☐ Male ☐ Female
5. Home telephone
6. Grade as of date of injury Level Step
7. Employee's home mailing address (Include city, state, and ZIP code)
8. Dependents
   - Wife, Husband
   - Children under 18 years
   - Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
10. Date injury occurred Mo. Day Yr. / Time ☐ a.m. ☐ p.m.
11. Date of this notice Mo. Day Yr.
12. Employee's occupation
13. Cause of injury (Describe what happened and why)
14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)

a. Occupation code
b. Type code
c. Source code
OWCP Use - NOI Code

[redacted]yee Signature

[redacted]ertify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ **Date**

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness
Signature of witness
Date signed
[redacted]ss
City
State
ZIP Code

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include city, state, and zip code) | OWCP Agency Code

OSHA Site Code

ZIP Code

18. Employee's duty station (Street address and ZIP code)

19. Employee's retirement coverage CSRS FERS Other, (identify)

20. Regular work hours From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

21. Regular work schedule Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

22. Date of Injury Mo. Day Yr.

23. Date notice received Mo. Day Yr.

24. Date stopped work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

25. Date pay stopped Mo. Day Yr.

26. Date 45 day period began Mo. Day Yr.

27. Date returned to work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

28. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

30. Was injury caused by third party? ☐ Yes ☐ No (If "No," go to item 32.)

31. Name and address of third party (Include city, state, and ZIP code)

me and address of physician first providing medical care (Include city, state, ZIP code)

33. First date medical care received Mo. Day Yr.

34. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? ☐ Yes ☐ No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work $ Per

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print)

Signature of supervisor Date

Supervisor's Title Office phone

39. Filing instructions
- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☐ No lost time, medical expense incurred or expected: forward this form to OWCP
- ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employees' behalf)

13) Cause of injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of Injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg: cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and filed CA-1 within thirty days of the injury, you may be entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. If you elect sick or annual leave you may not claim compensation to repurchase leave used during the 45 days of COP entitlement.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 39, the supervisor is responsible for obtaining the witness statement in Item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within 10 working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

19) Employers Retirement Coverage.

Indicate which retirement system the employee is covered under.

30) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

32) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

33) First date medical care received

The date of the first visit to the physician listed in item 31.

36) If the employing agency controverts continuation of pay, state the reason in detail.

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

a) The disability was not caused by a traumatic injury.

b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;

c) The employee is not a citizen or a resident of the United States or Canada;

d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;

e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;

f) The injury was not reported on Form CA-1 within 30 days following the injury;

g) Work stoppage first occurred 45 days or more following the injury;

h) The employee initially reported the injury after his or her employment was terminated; or

i) The employee Is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, "Recordkeeping and Reporting Guidelines.

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

Benefits for Employees under the Federal Employees' Compensation act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

(1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury and provide medical evidence in support of disability within 10 days of submission of the CA-1. Where the employing agency continue's the employee's pay, the pay must not be interrupted unless one of the provision's outlined in 20 CFR 10.222 apply.

(2) Payment of compensation for wage loss after the expiration of COP, if disability extends beyond such point, or if COP is not payable. If disability continues after COP expires, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious defringement of the head, face, or neck.

(4) Vocational rehabilitation and related services where directed by OWCP.

(5) All necessary medical care from qualified medical providers. The injured employee may choose the physician who provides initial medical care. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Chapter 20, Part 10) or pamphlet CA-810.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN), and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee) _____

Which occurred on (Mo., Day, Yr.) _____

At (Location)

_____

Signature of Official Superior | Title _____ | Date (Mo., Day, Yr.) _____

*U.S. GPO: 1999-454-845/12704

Notice of Occupational Disease and Claim for Compensation

U. S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of Employee (Last, First, Middle)

2. Social Security Number

3. Date of birth Mo. Day Yr.

4. Sex
M

5. Home telephone

6. Grade as of date of last exposure Level Step

7. Employee's home mailing address (Include city, state, and ZIP code)

8. Dependents
- ☐ Wife, Husband
- ☐ Children under 18 years
- ☐ Other

Claim Information

9. Employee's occupation

a. Occupation code

10. Location (address) where you worked when disease or illness occurred (include City, state, and ZIP code)

11. Date you first became aware of disease or illness
Mo. Day Yr.

12. Date you first realized the disease or illness was caused or aggravated by your employment
Mo. Day Yr.

13. Explain the relationship to your employment, and why you came to this realization

14. Nature of disease or illness

OWCP Use - NOI Code

b. Type code

c. Source code

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for the delay.

16. If the statement requested in item I of the attached instructions is not submitted with this form, explain reason for delay.

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government, agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ Date _____

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

For sale by the Superintendent of Documents, U.S. Government Printing Office Washington, DC 20402

Official Supervisor's Report of Occupational Disease: Please complete information requested below

Supervisor's Report

19. Agency name and address of reporting office (include city, state, and ZIP Code) | OWCP Agency Code

OSHA Site Code

ZIP Code

20. Employee's duty station (Street address and ZIP Code) ZIP Code

21. Regular work hours From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

22. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

23. Name and address of physician first providing medical care (include city, state, ZIP code)

24. First date medical care received Mo. Day Yr.

25. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

26. Date employee first reported condition to supervisor Mo. Day Yr.

27. Date and hour employee stopped work Mo. Day Yr. Time ☐ a.m. ☐ p.m.

28. Date and hour employee's pay stopped Mo. Day Yr. Time ☐ a.m. ☐ p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr.

30. Date returned to work Mo. Day Yr. Time ☐ a.m. ☐ p.m.

31. If employee has returned to work and work assignment has changed, describe new duties

32. Employee's Retirement Coverage ☐ CSRS ☐ FERS ☐ Other, (Specify)

33. Was injury caused by third party? ☐ Yes ☐ No If "No," go to Item 34.

34. Name and address of third party (include city, state, and ZIP code)

Signature of Supervisor

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of Supervisor (Type or print)

Signature of Supervisor Date

Supervisor's Title Office phone

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following general benefits for employment-related occupational disease or illness:

(1) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians of the employee's choice.

(2) Payment of compensation for total or partial wage loss.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

The first three days in a non-pay status are waiting days, and no compensation is paid for these days unless the period of disability exceeds 14 calendar days, or the employee has suffered a permanent disability. Compensation for total disability is generally paid at the rate of 2/3 of an employee's salary if there are no dependents, or 3/4 of salary if there are one or more dependents.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel off ice, should be studied BEFORE a decision is made to use leave.

If an employee is in doubt about compensation benefits, the OWCP District Office servicing the employing agency should be contacted. (Obtain the address from your employing agency.)

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual Payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Occupational Disease or Illness

This acknowledges receipt of notice of disease or illness sustained by:
(Name of injured employee)

I was first notified about this condition on (Mo., Day, Yr.)

At (Location)

Signature of Official Superior | Title | Date (Mo., Day, Yr.)

This receipt should be retained by the employee as a record that notice was filed.

INSTRUCTIONS FOR COMPLETING FORM CA-2

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. in addition to the information requested on the form, both the employee and the supervisor are required to submit additional evidence as described below. If this evidence is not submitted along with the form, the responsible party should explain the reason for the delay and state when the additional evidence will be submitted.

Employee (or person acting on the Employee's behalf)

Complete items 1 through 18 and submit the form to the employee's supervisor along with the statement and medical reports described below. Be sure to obtain the Receipt of Notice of Disease or Illness completed by the supervisor at the time the form is submitted.

1) Employee's statement

In a separate narrative statement attached to the form, the employee must submit the following information:

a) A detailed history of the disease or illness from the date it started.

b) Complete details of the conditions of employment which are believed to be responsible for the disease or illness.

c) A description of specific exposures to substances or stressful conditions causing the disease or illness, including locations where exposure or stress occurred, as well as the number of hours per day and days per week of such exposure or stress.

d) Identification of the part of the body affected. (If disability is due to a heart condition, give complete details of all activities for one week prior to the attack with particular attention to the final 24 hours of such period.)

e) A statement as to whether the employee ever suffered a similar condition. if so, provide full details of onset, history, and medical care received, along with names and addresses of physicians rendering treatment.

2) Medical report

a) Dates of examination or treatment.

b) History given to the physician by the employee.

c) Detailed description of the physician's findings.

d) Results of x-rays, laboratory tests, etc.

e) Diagnosis.

f) Clinical course of treatment.

g) Physician's opinion as to whether the disease or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion. (Medical reports that do not explain the basis for the physician's opinion are given very little weight in adjudicating the claim.)

3) Wage loss

If you have lost wages or used leave for this illness, Form CA-7 should also be submitted.

Supervisor (Or appropriate official in the employing agency)

At the time the form is received, complete the Receipt of Notice of Disease or Illness and give it to the employee. In addition to completing items 19 through 34, the supervisor is responsible for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form must be sent to OWCP within ten working days after it is received. In a separate narrative statement attached to the form, the supervisor must:

a) Describe in detail the work performed by the employee. Identify fumes, chemicals, or other irritants or situations that the employee was exposed to which allegedly caused the condition. State the nature, extent, and duration of the exposure, including hours per days and days per week, requested above.

b) Attach copies of all medical reports (including x-ray reports and laboratory data) on file for the employee.

c) Attach a record of the employee's absence from work caused by any similar disease or illness. Have the employee state the reason for each absence.

d) Attach statements from each co-worker who has first-hand knowledge about the employee's condition and its cause. (The co-workers should state how such knowledge was obtained.)

e) Review and comment on the accuracy of the employee's statement requested above.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

Item Explanation: Some of the items on the form which may require further clarification are explained below.

14. Nature of the disease or illness

Give a complete description of the disease or illness. Specify the left or right side if applicable (e.g., rash on left leg; carpal tunnel syndrome, right wrist).

19. Agency name and address of reporting office

The name and address of the off ice to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

23. Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a separate sheet of paper.

24. First date medical care received

The date of the first visit to the physician listed in item 23.

32. Employee's Retirement Coverage.

Indicate which retirement system the employee is covered under.

33. Was the injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the disease. For instance, manufacturer of a chemical to which an employee was exposed might be considered a third party if improper instructions were given by the manufacturer for use of the chemical.

Employing Agency - Required Codes

Box a (Occupational Code), Box b. (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Record Keeping and Reporting Guidelines.

OWCP Agency Code

This is a four digit (or four digit two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

• U.S. GPO: 2001480-204/59062

Authorization for Examination And/Or Treatment

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

The following request for information is required under (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108.
Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No.: 1215-0103
Expires: 9-30-2011

PART A - AUTHORIZATION

1. Name and Address of the Medical, Facility or Physician Authorized to Provide the Medical Service:

2. Employee's Name (last, first, middle)	3. Date of Injury (mo. day, yr.)	4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 11, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B.

A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services.

B. ☐ 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval.

☐ 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide. necessary conservative treatment if you believe the condition may be to the injury or to the employment.

7. If a Disease or Illness is Involved, OWCP Approval for Issuing Authorization was Obtained from: (Type Name and Title of OWCP Official)	8. Signature of Authorizing Official:
	9. Name and Title of Authorizing Official: (Type or print clearly)
10. Local Employing Agency Telephone Number:	11. Date (mo., day, year)
12. Send one copy of your report: (Fill in remainder of address)	13. Name and Address of Employee's Place of Employment:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

Department of Agency

Bureau or Office

Local Address (including ZIP Code)

SAMPLE

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Form CA-16
Rev. Feb.2005

PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (Last, first, middle)

15. What History or Injury or Disease Did Employee Give You?

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe)
☐ Yes ☐ No

16a. IDC-9 Code

17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)

18. What is Your Diagnosis?

18a. IDC-9 Code

19. Do You believe the Condition Found was Caused or Aggravated by the Employment activity Described? (Please explain your answer if there is doubt)
☐ Yes ☐ No

20. Did Injury Require Hospitalization? ☐ Yes ☐ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. Is Additional Hospitalization Required?
☐ Yes ☐ No

22. Surgery (If any, describe type)

23. Date Surgery Performed (mo., day, year)

24. What (Other) Type of Treatment Did You Provide?

25. What Permanent Effects, If Any, Do You Anticipate?

26. Date of First Examination (mo., day, year)

27. Date(s) of Treatment (mo., day, year)

28. Date of Discharge from Treatment (mo., day, year)

29. Period of Disability (mo., day, year) (If termination date unknown, so indicate)
Total Disability: From To
Partial Disability: From To

30. Is Employee Able to Resume
☐ Light Work Date:
☐ Regular Work Date:

31. If Employee Is Able to Resume Work, Has He/She been Advised? ☐ Yes ☐ No If Yes, Furnish Date Advised

32. If Employee is Able to Resume only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.

33. General Remarks and Recommendations for Future Care, if indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? ☐ Yes ☐ No (If yes, state specialty)

35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand, that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

36. Address (No., Street, City, State, ZIP Code)

37. Tax Identification Number

38. National Provider System Number

39. Date of Report

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF PHYSICIAN

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical office or hospital or any duly qualified physician/ hospital of the employee's choice.

- If the employee elects to be treated by a private physician, a copy of the American Medical Association standards billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA-16.

- A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

- Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF AUTHORIZATION

- Form CA-16 is valid for up to sixty days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

FEDERAL MEDICAL FACILITIES

- U.S. medical facilities include Public Health Service, Military, or VA hospitals. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

DEFINITION OF INJURY

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

DEFINITION OF PHYSICIAN

- The term "physician" includes doctors of medicine (MDs), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

FORM COMPLETION

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in Item 1 and the signature of the authorizing official appears in Item B. Check B1 or B2 or Item 6, whichever is appropriate. In care of illness or disease, only Box B2 may be checked.

- Show the address of the proper OWCP Office in Item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

See 20 CFR and/or Chapter 810, Federal Personnel Manual (FPM).

Information for Physician -- See Reverse Side

INFORMATION FOR PHYSICIAN

YOUR AUTHORIZATION

- Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in Item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated eadier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A. Item 12.

This form covers office visits and consultations, laboratory work, hospital services (including inpatient), x-rays, MRIs, CT scans, physical therapy, emergency services (including surgery) and chiropractic services. Chiropractic services are limited to charges for physical examinations and x-rays to diagnose a subluxation of the spine and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by x-ray.

This form does not cover elective and non-emergency surgery, home exercise equipment, whirlpools, mattresses, spa/gym membership and work hardening programs.

USE OF CONSULTANTS AND HOSPITALS

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accommodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.

REPORTS

- After examination, complete items 14 through 39, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA 17, "Duty Status Report" may be required by the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.

RELEASE OF RECORDS

- Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

BILLING FOR SERVICES

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified. In Column 24 C of the form, by the applicable Current Procedural Terminology (0 editor) Code CPT 4). A copy of the form may be supplied by the employee at the time treatment is sought.

- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

TAX IDENTIFICATION NUMBER

- The provider's Tax Identification Number (TIN) is an important identified in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN - either corporate or personal - which is used consistently on OWCP claims.

ADDITIONAL INFORMATION

- Contact the OWCP shown in Item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.

* U.S. GPO: i999-454-845/92710

PRIVACY ACT

"NOTE: The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is Section 81 01, et seq., Title 5 of the U.S. Code authorizes collection of this information. Completion of this form is required in order to receive payment for medical services and expenses associated with the injury or disease described in Item 5 of this form for a period not more than 60 days from the date of issuance, subject to the condition in Item 6 of this form. Additional disclosures of this information may be to: third parties in litigation; employing agencies, various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus."